Chapter XVI

OTHER AREAS OF MONITOR INQUIRY

During the first year of the MBC Enforcement Monitor project, the Monitor was unable to examine several components of MBC's enforcement program that deserve mention. These "back end" components of the enforcement program include the Board's citation and fine program, its Probation Unit, and the Physician Assessment and Clinical Education (PACE) program at the University of California San Diego School of Medicine.

A. MBC's Citation and Fine Program

Business and Professions Code section 125.9 authorizes MBC to implement, by regulation, a system for the issuance of citations, fines, and orders of abatement for minor or technical violations of the Medical Practice Act or the Board's regulations.

The citation and fine remedy generally. Enacted in 1986, the purpose of the citation and fine remedy was to "bridge the gap" between the two sanctions then available to most occupational licensing boards to address violations of statute or regulation by their licensees: (1) institution of the full-blown and costly (to both board and licensee) adjudicative proceeding under the Administrative Procedure Act (APA) described in the first twelve chapters of this report — complete with filed accusation, representation of the board by the Attorney General's Office, evidentiary hearing by an administrative law judge (ALJ) from the Office of Administrative Hearings, board review of the resulting ALJ proposed decision, board adoption of a final disciplinary decision, and judicial review of the board's decision; and (2) nothing. At that time, most boards had no "intermediate remedies" enabling them to deal with violations of statute or regulation which are not serious enough to merit a full-blown adjudicatory proceeding, but should not be ignored and/or addressed via a private "slap on the hand" which is never thereafter tracked by the licensing board. The citation and fine remedy was the first of those "intermediate remedies" to be enacted and authorized, and was intended to be a relatively quick and decisive alternative to the lengthy disciplinary process in situations where the violation is technical or minor in nature.

As enacted in 1986, section 125.9(a) authorizes most DCA boards to issue a "citation which may contain an order of abatement or an order to pay an administrative fine . . . where the licensee is in violation of the applicable licensing act or any regulation adopted pursuant thereto." Section 125.9(b) requires agencies to adopt regulations setting forth the precise procedure they will utilize in issuing citations and fines. The procedure must afford any cited licensee a written citation which describes "with particularity" the nature of the violation. Further, the procedure must include an opportunity for the cited licensee to request a full hearing pursuant to the APA. Any licensee who avails him/herself of this right is entitled not only to a hearing before an ALJ, but also to board review of the ALJ's proposed decision and court review of the board's decision. As amended in 2003, section 125.9(b)(3) permits agencies to accompany a citation with a fine not to exceed $5,000 per violation; in assessing the amount of any fine, consideration must be given to specifically-identified criteria (including the gravity of the violation, the good faith of the licensee, and the history of previous violations).

MBC's implementation of the citation and fine remedy. As noted in the *Initial Report*, MBC did not implement its citation and fine authority until 1994.[340] At that time, MBC adopted section 1364.10 *et seq*., Title 16 of the California Code of Regulations. Of import, section 1364.10 permits a "board official"[341] to determine when and against whom a citation should be issued, and to issue citations including orders of abatement and fines. Section 1364.11 identifies statutory and regulatory provisions whose violation may justify the issuance of a citation, fine, and/or order of abatement.[342]

Section 1364.14 sets forth the procedure for challenging a citation. In addition to the "process" required by the statute, the regulation allows a cited licensee to request, within ten days after service of the citation, an informal conference with the board official who issued the citation. If the physician requests an informal conference, the board official must schedule one within 30 days of the request. At the conclusion of the informal conference, the board official may affirm, modify, or dismiss the citation, including any fine levied or order of abatement issued. Within ten days after the informal conference, the board official must "state in writing the reasons for his or her action and serve or mail a copy of his or her findings to the person cited. . . .This decision shall be deemed to

[340] *Initial Report*, *supra* note 13, at 37.

[341] The term "board official" is defined to include the chief, deputy chief, or supervising investigator II of the Board's enforcement program, and the Board's chief of licensing. 16 CAL. CODE REGS. § 1364.10(a).

[342] At this time, MBC is in the process of amending section 1364.11 to include several additional provisions whose violation will justify the imposition of a citation and fine. The Board also intends to implement SB 362 (Figueroa) (Chapter 788, Statutes of 2003), which increased the statutory ceiling on fines from $2,500 to $5,000 per violation. MBC's proposed amendments to section 1364.11 would permit it to impose a $5,000 fine where the cited person has received two or more prior citations for the same or similar violations, or where the citation involves multiple violations that demonstrate a willful disregard for the law.

be a final order with regard to the citation issued, including the fine levied and the order of abatement."[343] Thus, the Board's implementation of section 125.9 affords the licensee four levels of procedural due process protection — informal conference, ALJ hearing, DMQ review of ALJ decision, and court review of DMQ's decision — both as to sanction generally and as to the degree of sanction.

2004 changes to MBC's processing of citation and fine cases. In May 2004, the California Medical Association complained to MBC that two physicians had recently been issued citations without ever having been contacted prior to their issuance. At about the same time, MBC's handling of citation and fine cases changed significantly — largely as a result of the assignment of a deputy attorney general and a supervising investigator to the Central Complaint Unit. As described briefly in the *Initial Report*,[344] these individuals examined MBC's citation and fine program and prompted several important policy changes that have since been codified in MBC's various procedure manuals.[345]

Cases in which the citation and fine remedy is appropriate may be identified by the Central Complaint Unit or by MBC district offices during investigation. MBC's procedure manuals now clarify that, in either case, a citation will not be issued unless staff has first contacted the subject physician for information, an explanation, and an attempted resolution.[346] In practice, MBC's goal is to encourage compliance with the law. Complaints warranting a citation and fine — such as a complaint about misleading advertising, a physician's failure to distribute a statutorily-required brochure to a patient, or inadequate medical recordkeeping — can be and often are resolved before a citation is issued. If a contacted physician responds to MBC and agrees to change his/her behavior, compliance has been achieved and the citation will likely not be issued.

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[343] 16 CAL. CODE REGS. § 1364.14(b). If the board official sustains the issuance of the citation, the cited physician has 30 days within which to file a written request for a hearing before an ALJ. Bus. & Prof. Code § 125.9(b)(4).

[344] *Initial Report*, *supra* note 13, at 82.

[345] The 2004 changes to the way in which citation and fine cases are reviewed are reflected in the Board's *Citation and Fine Manual*, which was completely rewritten effective September 15, 2005. MBC's handling of citation and fine cases identified in the Central Complaint Unit is additionally governed by section 8.5 of the *CCU Procedure Manual* (newly added as of January 30, 2005); citation and fine cases identified in MBC's field offices are governed by section 9.3 of its *Enforcement Operations Manual*, which was revised in October 2004.

[346] *CCU Procedure Manual* § 8.5. The only exception to this notice requirement is in cases where MBC cannot locate the physician because he/she has not notified MBC of a change to his/her address of record; in those cases, the physician will be issued a citation (not a fine) for failure to notify the Board of the address change as required by law (a so-called "change of address citation").

If the physician disputes the matter or has been the subject of similar complaints and cited/fined for similar conduct in the past, MBC will proceed with the citation and fine remedy. A citation and fine case identified in the Central Complaint Unit is first reviewed by the appropriate CCU manager (depending on whether the underlying case is a quality of care case or a physician conduct case). If the manager agrees that the citation and fine remedy is appropriate, the file is referred to the supervising investigator and the deputy attorney general assigned to CCU; they review the file to determine whether it includes sufficient evidence of the violation (including documentation of MBC's written contact with the physician and the physician's response, if any). If so, the matter is transferred to the Board's citation and fine analyst, who prepares the citation for signature by the Board's enforcement chief — who again reviews the file for sufficiency of the evidence and actually "issues" the citation by signing it. Citation and fine cases identified in MBC's field offices undergo similar review: The district office investigator prepares an investigative report recommending a citation, which must be reviewed and approved by the office's supervising investigator and the DIDO DAG assigned to the office — at which point the matter is referred to the citation and fine program analyst and then the enforcement chief.

Exhibit XVI-A below reflects MBC's recent citation and fine activity, and indicates a significant decline in the number of citations and fines issued in recent years. MBC insists that it is utilizing the citation and fine remedy judiciously, and mostly in an attempt to educate physicians about their legal responsibilities and encourage compliance with the law. The numbers appear consistent with this claim. The vast majority of citations issued over past three years are citations (with no fines) for failure to notify the Board of a change of address. Many (if not most) citations are withdrawn when compliance is achieved — including change of address citations (which are withdrawn without the necessity of an informal conference once the physician submits updated address of record information). During 2004–05, CCU issued 59 advisory and educational letters (40 of which were in quality of care cases) to physicians in lieu of citations and fines — which accounts (in part) for the dramatic decrease in the number of citations issued in 2004–05.

Ex. XVI-A. Citation and Fine Activity

	FY 2002–03	FY 2003–04	FY 2004–05
Total citations/fines issued	532	423	307
Change of address citations	340	327	248
Other citations without fines	1	0	1
Citations with fines	191	96	58
Total fines ordered	$49.7 million	$3.4 million	$152,100
Total fines collected	$83,120	$76,770	$36,900
Informal conferences requested	91	56	30
Citations/fines withdrawn	174	144	75
ALJ hearings requested	6	3	0

Source: Medical Board of California

Thus, MBC has addressed CMA's complaint. Under current Board policy, MBC must contact any physician against whom a citation/fine is being contemplated and seek information. Further, in many cases where MBC chooses to proceed with a citation/fine, it notifies the physician in writing that a citation will be issued within ten days[347] — thus affording the licensee another chance to make contact with the agency and resolve the matter. As noted above, any citation that is issued to a physician includes a notice that the physician may, within ten days of the issuance, request an informal conference with the board official who issued the citation. These informal conferences provide another opportunity for MBC and the physician to communicate about the violation, and for MBC to suggest remedial continuing education courses which would provide information regarding the violation to the physician. If the physician agrees to take the course or otherwise change his/her behavior as a result of the informal conference, the board official may withdraw the citation.

Public disclosure of citations and fines. Citations are not considered "disciplinary actions" because they have not been issued by the Division of Medical Quality.[348] However, citations are public information, and are required to be posted on MBC's Web site.[349] Pursuant to Board regulation,[350] citations and fines are posted for a period of five years from the date of resolution, and then are purged; a citation that has been withdrawn or dismissed is purged immediately upon being withdrawn or dismissed.

In its May 2004 complaint, CMA also questioned the fairness of MBC's posting of citations on its Web site upon issuance, before the physician has had an opportunity to request and participate in the informal conference and the "full due process hearing" before the ALJ. This issue presents a closer question. MBC is authorized to "issue" citations,[351] and it is required to post them when they are "imposed."[352] Although CMA argues that there is a clear difference between "issued" and "imposed," the Monitor is not convinced.

The bottom line is that citations/fines are not disciplinary actions and physicians are given several opportunities to resolve them before they are issued. The Board's longtime practice has been

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[347] *CCU Procedure Manual* § 8.5 at 2–3.

[348] However, failure to comply with an order of abatement or to pay a fine may result in result in formal disciplinary action.

[349] Business and Professions Code section 2027(a)(8) requires MBC to post "[a]ny information required to be disclosed pursuant to Section 803.1," and section 803.1(a)(5) requires MBC to post "[i]nfractions, citations, or fines imposed."

[350] 16 CAL. CODE REGS. § 1364.15.

[351] Bus. & Prof. Code § 125.9.

[352] *Id*. § 803.1(a)(5).

to warn first and cite later (for ignorance of the warning and repetition of the violation). During 2004–05, the Board has established a clear record of utilizing educational letters in lieu of citations/fines, such that most citations now being issued are either for repeated violations or for uncontestable failure to notify the Board of a change of address (which would be of no concern to reasonable consumers). MBC's 2004 policy changes assure that physicians received notice at least once (if not twice) before any citation is either "issued" or "imposed," such that physicians have an opportunity to talk or meet with board officials and resolve the matter. The Board's new investigator/attorney review procedures ensure that MBC staff has gathered sufficient evidence (including the Board's written contact with the physician and the physician's response) to support issuance of a citation. According to the Board's enforcement chief, the Web posting upon "issuance" is the only event that attracts the attention of some physicians and enables MBC and its medical consultants to insist on coursework as a condition of withdrawing the citation. The Monitor is informed that MBC representatives met with CMA in March 2005 and offered to institute a procedure whereby MBC will formally notify all physicians ten days in advance of "issuance" and posting that they are about to be cited — in a last attempt to elicit information and cooperation from the physician; according to MBC, CMA has not responded to that offer. In light of all the above, the Monitor finds that offer reasonable and is not prepared to recommend other changes in MBC's practice regarding the posting of citations upon their "issuance."

B. MBC's Probation Unit

Business and Professions Code sections 2227(a)(3) and 2228 authorize DMQ to place the license of a physician on probation subject to specified terms and conditions. In its 2003 disciplinary guidelines, DMQ has identified approximately 35 standard and optional terms and conditions of probation that it may include in a disciplinary order depending on the circumstances of the case. Through probation, DMQ may restrict a license (for example, it may prohibit a physician from prescribing certain types of controlled substances, practicing without a third-party chaperone, or engaging in solo practice) or condition continued practice on participation in the Board's Diversion Program for substance-abusing licensees; require a physician to take and pass a professional competency exam, psychiatric examination, ethics and/or other continuing education courses, or to undergo psychotherapy or other medical evaluation and treatment; and/or require participation in the Physician Assessment and Clinical Education (PACE) program (see below).

Since 1992, MBC has maintained a centralized Probation Unit whose purpose is to protect the public by ensuring that any physician whose license has been placed on probation complies with the terms and conditions imposed in the probationary order. Under the direction of a deputy chief of enforcement and headed by a supervising investigator II, MBC's Probation Unit includes offices in Sacramento, Rancho Cucamonga, and Cerritos. Each regional office is headed by a supervising investigator I. Overall, the unit currently includes 14 sworn peace officer probation investigators,

two investigative assistants, and three retired annuitants.[353] The Unit's investigators monitor an assigned caseload of probationers to ensure that imposed probationary terms and conditions are met; additionally, they investigate new complaints filed against one of their assigned probationers.[354]

When a physician's license is put on probation, the assigned probation investigator conducts an intake interview with the physician to secure his signature on various acknowledgment forms and to explain each term and condition of probation to ensure that the physician understands DMQ's expectations. Thereafter, the probation investigator is expected to meet with the probationer at least quarterly; these visits may be scheduled or unannounced. Probation investigators may also meet with any required practice monitor of the probationer, and must generally ensure that the probationer is fulfilling all required terms and conditions of the probationary order. On a quarterly basis, each probation investigator submits a report on each probationer in his/her caseload to the supervising investigator, and that supervisor records completed probation reports and other events (such as the completion of required educational courses or the passage of competency exams) in MBC's CAS computer system.

Effective January 1, 1996, SB 609 (Rosenthal) (Chapter 708, Statutes of 1995) amended Business and Professions Code section 2227(a)(3) to permit the Board to recoup the costs of its probation monitoring from probationers. Since then, MBC has imposed an annual probation monitoring fee on probationers (which is currently $3,173 per year); in 2004–05, MBC ordered the payment of $922,540 and actually collected $838,626 in cost reimbursements from its probationers.

Ex. XVI-B. Probation Unit Activity

	FY 2001–02	FY 2002–03	FY 2003–04	FY 2004-05
Number of in-state probationers	498	516	547	545
Probation violations referred to AG	27	12	34	32
Petition to revoke probation filed	21	18	26	26

Source: Medical Board of California

Exhibit XVI-B above reflects recent Probation Unit activity. At any given time during the past four fiscal years, the Probation Unit has monitored approximately 526 probationers. Probation investigators carry an average caseload of 40 probationers, plus an additional five investigations of

[353] Prior to 2001, the Probation Unit included 17 sworn investigators; three investigator positions were lost in the hiring freeze. Additionally, the supervising investigator II position and two of the supervising investigator I positions were lost for several years, but have now been reinstated.

[354] In addition to monitoring disciplined physicians, Probation Unit investigators may monitor physicians who have been granted a probationary license by MBC's Division of Licensing; occasionally, they also investigate new "overflow" complaints and reports of physician misconduct.

new complaints against existing probationers; these high caseloads sometimes preclude quarterly in-person meetings between probationer and probation investigator. Collectively, the Probation Unit refers an average of 26 probation violations to HQE, and HQE files an average of 23 petitions to revoke probation every year. According to MBC, HQE DAGs have traditionally been hesitant to file petitions to revoke probation for relatively minor noncompliance with probationary terms; however, MBC has had no other remedy to address that noncompliance. To fill that loophole, MBC is in the process of amending its citation and fine regulations to authorize it to utilize that sanction to address probation violations that do not warrant a petition to revoke probation.[355]

C. The Physician Assessment and Clinical Education Program

When inserted into a formal disciplinary order, optional condition #19 of DMQ's disciplinary guidelines requires a respondent physician to "enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education (PACE) Program at the University of California San Diego School of Medicine."

Founded in 1996 by UCSD Professor of Clinical Family Medicine William A. Norcross, M.D., the PACE program offers a relatively unique service — it provides clinical competency assessment for physicians and delivers remedial education for detected deficiencies in the core clinical competency areas identified by the American Council on Graduate Medical Education (ACGME).[356] Although the staff of the PACE program is relatively small, it is able to call upon the full resources of the UCSD School of Medicine — including 40–50 physicians who are board-certified and experienced in all medical specialties and subspecialties — to assist in the assessment, evaluation, and remedial education of program participants. PACE is the oldest and most experienced program of its kind — and one of very few — in the nation. Having observed Dr. Norcross make numerous presentations to DMQ about PACE since its inception, the Monitor knows that PACE has continuously evolved and enhanced its services to meet the needs of the Medical Board of California and other medical boards whose licensees it assesses.

Currently, the basic PACE program consists of two phases. Phase I involves a comprehensive assessment of the physician participant and his/her clinical skills which is tailored to the specialty in which the participant practices. Phase I includes a complete history and physical

[355] Specifically, MBC is in the process of amending section 1364.11, Title 16 of the California Code of Regulations, to add new subsection (b), which will state: "In his or her discretion, a board official may issue a citation under Section 1364.10 to a licensee for a violation of a term or condition contained in the decision placing that licensee on probation."

[356] The six core clinical competencies identified by the ACGME are (1) patient care, (2) medical knowledge, (3) practice-based learning and improvement, (4) interpersonal and communication skills, (5) professionalism, and (6) systems-based practice.

examination of the participant, and completion of several questionnaires and "self-report" forms by the participant which are designed to elicit information regarding personal health behaviors, educational and training experiences, habits of continuing professional development, and medical practice history. The participant must undergo a computerized neurocognitive examination (which is normed for physicians by age so as to be able to detect early dementia); a one-hour clinical examination in the participant's specialty that is administered by a PACE faculty member in the same specialty; a number of computerized patient simulation/patient management scenarios, with a subsequent review of the participant's thought processes by a PACE faculty member; and several standardized post-licensure examinations created by the National Board of Medical Examiners (which has authorized PACE to administer them). Additionally, during Phase I, a PACE faculty member in the participant's specialty performs a chart review of a random sample of the redacted medical records of patients personally treated by the participant; and the participant is required to perform a complete history and physical on a patient (one of the PACE staff), which is videotaped and later evaluated by a PACE faculty member.[357]

At the completion of Phase I, PACE holds a multidisciplinary staff meeting to discuss the results of all aspects of the assessment.[358] The results of Phase I, along with recommendations by PACE staff, are communicated to a PACE faculty member for incorporation into Phase II — a five-day clinical education program onsite at the UCSD Medical Center. While PACE participants do not have direct responsibility for patient care, they are integrated into the full spectrum of specialty-specific educational opportunities offered at a busy academic health center teaching service. Under the guidance of a PACE faculty mentor, these opportunities typically include outpatient clinics, inpatient ward rounds, grand rounds and other conferences, and observation of procedures. To the greatest extent possible, PACE customizes Phase II to the results of the Phase I assessment, the

[357] In October 2004, PACE added a so-called "360-degree assessment" tool to Phase I. This tool, whose use is required in Canada, requires the physician participant to identify eight physician colleagues and eight non-physician staff colleagues, all of whom are surveyed about the participant and his/her clinical skills; additionally 25 randomly-selected patients of the physician complete questionnaires about the participant. The surveys are completed anonymously and returned to a third-party entity which compiles the data and creates an initial report flagging perceived deficiencies and identifying strengths. Six months after completion of Phase II remedial education and training, the eight physician colleagues, eight non-physician staff colleagues, and 25 other patients of the physician are surveyed — so that PACE can evaluate whether Phase II has been effective in addressing deficiencies in the physician's clinical competencies, and whether the physician has learned and applied that learning to his practice. As noted above, PACE just added this component in October 2004, so it is only now starting to receive summary reports. According to PACE staff, the "360-degree assessment" is not helpful with those who may need it most — physicians who are sole practitioners and who, in the words of Dr. Norcross, are "intellectually and geographically isolated" — because they do not have eight colleagues and eight support staff who have observed their practice and are capable of evaluating them.

[358] In August 2005, the Monitor attended one of these staff meetings and witnessed staff's impressive presentation and discussion of eight cases. Although one staff member took primary responsibility for the oral presentation of each case, all other staff members actively reviewed the results of all Phase I examinations and questionnaires in that case (they were physically distributed around the table for inspection) and quizzed the presenter about the details of the case until all had a complete understanding of the facts and could contribute to the recommendation in the case.

perceived deficiency which has resulted in the physician's referral to PACE, and the instructions of DMQ. Also during Phase II, the participant is required to complete several evidence-based medicine research projects requiring Internet and other research and writing.

At the conclusion of Phase II, the PACE faculty member prepares a report on the participant's performance, which is reviewed by a multidisciplinary group and from which a detailed report is drafted for submission to DMQ. In the report, PACE determines whether the physician has successfully completed the program, as required by the DMQ probation order. Most physicians who have enrolled in PACE have successfully passed the program.

In July 2004, PACE introduced a new Physician Enhancement Program (PEP) which can occur subsequent to completion of Phases I and II. PEP involves an individualized practice review by a PACE faculty member, and can provide a practice monitor where DMQ requires one. The enhanced PEP program involves an initial and annual practice review by a PACE faculty member; monthly chart reviews by PACE physicians who practice in the same specialty as the participant; a "360-degree assessment" if possible; creation of an individualized personal and practice development plan (including suggested coursework); and monthly telephone conversations between the participant and the PACE faculty member. Additionally, PACE has developed and offers courses that are often required by DMQ as a condition of probation, including courses in prescribing, medical recordkeeping, clinician-patient communication, professional boundaries, researching medical literature, and anger management for health care professionals.

Currently, PACE is working with MBC and HQE to tackle a difficult issue — the creation of a program to assess and remediate surgical skills. Still in the development stage, this program may involve computerized simulated surgeries, proctoring/supervision during surgery, audio- and videotaping of surgical procedures, and both a pre- and post-program chart review of the physician's surgical patients. In cooperation with MBC and HQE, PACE is examining complex issues surrounding the creation of a surgical skills assessment program — including patient consent, confidentiality, and liability issues; the cost of such a program; and the criteria that should be considered and applied by DMQ when requiring a physician to complete such a program.

In the Monitor's view, MBC, its licensees, and California patients are fortunate that MBC has ready access to the professionals at PACE and the comprehensive assessment and education programs that PACE has developed in its nine-year existence. Our interviews of PACE, MBC, and HQE staff indicate that PACE management has established an excellent working relationship with HQE and MBC enforcement staff. PACE communicates frequently with MBC enforcement and probation staff about the progress of referred physicians in enrolling and completing PACE requirements, and has worked cooperatively with HQE prosecutors to develop a "template" expert declaration in the event that it determines a physician is incompetent to practice medicine. PACE

has responded constructively to every request and requirement of DMQ, including concerns regarding the length of time it takes physicians to enroll in and complete the program.

It appears that PACE can be counted on to conduct a thorough, respectful, and unbiased assessment of physician clinical competency, and that it is willing — when circumstances require — to testify that a physician is not competent to practice based on its evaluation of that physician. Although optional condition #19 of MBC's disciplinary guidelines allows a physician to complete PACE or an "equivalent" clinical assessment and education program, not all such programs are created equal. Over the years, several alternative programs have ceased to exist because they were not affiliated with a large institution and lacked the volume of participants needed to make them economically stable. DMQ would be well-advised to ensure that any alternative program claiming to be "equivalent" administers the same comprehensive multilevel assessment techniques and examinations, demands the same depth and breadth of remedial education, and is as responsive to DMQ as PACE has been throughout its existence.